INDIANA COMPREHENSIVE HEALTH
INSURANCE ASSOCIATION (ICHIA)

www.online-Healthplan.com®

BY PHONE (8:00 am - 4:00 pm)**:**
1.800.552.7921 or
317.614.2133

ICHIA-015 Rev. 12/03

INDIANA COMPREHENSIVE HEALTH
INSURANCE ASSOCIATION (ICHIA)

Applicant Information

HOW DO I APPLY FOR A POLICY?

It's easy to apply. Step 1: You must appliy to Medicaid within 60 days prior to sending an application to ICHIA. **Step 2**: Provide a fully executed Medicaid Application Verification Form. **Step 3**: Select the Plan right for you. Once you have determined which Plan is right for you, simply complete the enclosed application and return it to the address on the form.

All sections of the application must be completed in their entirety. A checklist is provided to help guide you through the application process. Remember, premium payment is due at the time of application.

If at any time while completing the application you have questions, please contact our customer service department at **1.800.552.7921** or **317.614.2133**. You can also visit us **on-line at www.online-Healthplan.com®** where you can view additional information about the ICHIA Plan or use our Ask-a-CSR inquiry system to send an electronic message to a customer service representative (CSR).

Once your application is approved, we will send you a benefit guide, certificate of coverage (insurance policy), PPO directory and an identification card. Both the benefit guide and the certificate of coverage provide specific details of your Plan's benefits and the procedures you need to follow in order to get the maximum benefits to which you are entitled.

MATERIALS INCLUDED WITH THIS BROCHURE

Plan Options (Plan 1, 3A and 3B)
A detailed snapshot of the covered benefits under each plan including deductible and coinsurance levels. The easy to read grid allows you to quickly and easily choose which plan is right for you.

Premium Rate Table
The premium rate table is organized by Plan allowing an instant comparison of rates for monthly and quarterly.

Application Packet
The application packet provides you with all of the information necessary to apply for coverage.

Any provision of this Policy (including a benefit reduction) is subject to change as mandated by Indiana or federal law or by the Board of Directors of ICHIA.

Thank you for your interest in health care coverage with the Indiana Comprehensive Health Insurance Association (ICHIA). We look forward to serving you soon.

DO I QUALIFY FOR AN ICHIA POLICY?

To be eligible for an ICHIA policy, you must meet all of the general requirements and one of the eligibility categories.

GENERAL REQUIREMENTS

1. You must be a resident of the state of Indiana ("resident" refers to a person who has for at least 12 months immediately preceding this application for insurance resided continuously in the state of Indiana in a place of permanent habitation). **This residency requirement does not apply to applicants that are "Federally Eligible";**
   and
2. You are not eligible for Medicaid; and
3. You do not have and are not eligible for an insurance plan that equals or exceeds the MINIMUM requirements for accident and sickness insurance policies issued in Indiana.

ELIGIBILITY CATEGORIES

Federally Eligible - You are federally eligible if on the date you apply for coverage with ICHIA, you have had continuous creditable coverage for at least 18 months with no lapse in coverage exceeding 63 days. Your most recent coverage must have been under a group plan, and if offered COBRA benefits, you must have exhausted your COBRA benefits. A copy of the Certificate of Creditable Coverage from your past health insurer / employer is used as proof of federal eligibility.

Federal eligibility is determined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which allows individuals to avoid a pre-existing condition waiting period when changing from one carrier to another.

Rejection for Other Health Coverage - Received notification of rejection from a health insurer for coverage that equals or exceeds the MINIMUM requirements for accident or sickness insurance policies issued in Indiana.

Premium Rate Higher Than ICHIA - I am currently on an individual policy and am not eligible for any coverage that equals or exceeds the minimum requirements for Accident and Sickness policies in Indiana. I received a premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA

WHAT IS ICHIA?

The Indiana Comprehensive Health Insurance Association (ICHIA) was created by the Indiana Legislature to offer an alternative for health insurance coverage to the residents of Indiana who experience problems in obtaining or keeping health insurance due to a medical condition.

HOW TO CONTACT US

ON THE WEB:
www.online-Healthplan.com®

BY PHONE (8:00 am - 4:00 pm)**:**
1.800.552.7921 or
317.614.2133

VIA MAIL:
ICHIA
P.O. Box 33730
Indianapolis, IN 46203-0730

IN PERSON (8:00 am - 4:00 pm)**:**
Administrator's Office
ACS Healthcare Solutions (ACS)
4550 Victory Lane
Indianapolis, IN 46203

WHAT BENEFITS ARE OFFERED BY ICHIA?

The choice is yours. ICHIA offers three comprehensive Plans that include a preferred provider organization (PPO) benefit. Each Plan has its own deductible, coinsurance and benefit levels.

HOW THE PPO WORKS

With the ICHIA health care plan, you may choose any physician, hospital or other medical care provider and receive the benefits covered under your Plan upon presenting your insurance identification card.

You also have the option to choose a physician or hospital from the preferred provider organization (PPO). When you do, you'll receive those services at a reduced rate.

PPO Advantages

A PPO is a network of providers who have entered into an agreement to accept a discounted fee for their services. Using a provider from the PPO saves you money because a higher percentage of your out-of-pocket costs will be paid by ICHIA.

When you use a network provider, the plan will pay a higher percentage of your covered costs. You will pay only the deductible, coinsurance and charges for non-covered services.

In addition to lower rates for covered services, PPO providers handle all of the paperwork for you so you will have no claims to file.

About Preferred Provider Organization

ICHIA uses a preferred provider network (PPO), which represents a full range of medical specialties and includes hundreds of specialists and internists across Indiana to provide you with the best care possible.

Ask your provider if he or she is a preferred provider or search the provider directory from our web site at www.online-Healthplan.com®.

Using other providers

If you receive care from a non-network provider, your benefit payment will be reduced. The non-network provider may also charge you more than the plan allows for that treatment or service and expect payment at the time services are rendered. The amount in excess of what the Plan will pay is your responsibility and does not apply to your deductible or coinsurance requirements.

In addition, with non-preferred providers, you are responsible for filing your own claims.

Medco Health prescription drug network

The ICHIA health care plan also gives you access to a nationwide network of pharmacies. Through the Medco Health pharmacy network you will benefit from negotiated discounts on your prescription drugs upon presenting the Medco Health Prescription identification card. The deductible and coinsurance / copayment amounts differ among ICHIA plans (see the covered benefit insert for details on each plan).

COVERED BENEFITS

A detailed listing of covered benefits by Plan are included in the insert accompanying this brochure. Services are provided for inpatient and outpatient services including professional services (office visits), hospital expenses, mental illness / substance abuse, skilled home health care, skilled nursing facility expenses, surgical and transplant services. (Some of these services require precertification approval.)

HOW PREMIUM RATES ARE DETERMINED

Premium rates, as listed in the insert, are based on the geographic area of Indiana in which you reside, your age and sex. Rates are subject to change with 30 days notice.

Premium payment cycles. ICHIA offers several different payment cycles, including two monthly premium payment options - you can receive your premium invoice each month via U.S. mail or have your premium automatically deducted from your bank account by completing an authorization form.

Quarterly allowable payment cycles are also available.

Deductibles. The amount of eligible expenses each member must pay before ICHIA benefits are paid is called a deductible. The deductible must be satisfied once each calendar year. A separate deductible applies to the prescription drug benefit for Plans 3A and 3B.

The deductible is accumulated on a calendar year basis (January 1 to December 31) regardless of when your coverage becomes effective. Exception: Under Plans 3A and 3B, out-of-pocket expenses incurred in the last quarter of the previous calendar year (October, November and December) may be used to satisfy the deductible for the next calendar year.

Coinsurance. ICHIA pays 80% of in-network (60% of out-of-network) covered charges once the deductible has been satisfied. The member is responsible for the coinsurance amount of 20% for in-network (40% for out-of-network) covered charges. Coinsurance amounts are in addition to any charges incurred due to using an out-of-network provider (such as charges over the usual and customary allowance).

Out-of-pocket maximum. Under each ICHIA Plan, a limit is based on how much your share of eligible expenses is per year (deductible plus coinsurance) before the Plan pays 100% of the allowable expenses for the remainder of the calendar year.

Once you reach the out-of-pocket maxiumum, you will no longer be required to pay coinsurance - ICHIA will pay 100% of covered charges under your Plan.

Deductible, coinsurance and out-of-pocket maximums for each ICHIA Plan are detailed in the covered benefits insert included in this brochure.

ALLOWABLE EXPENSES are those charges for health care services and supplies provided for by ICHIA, and charges based upon our usual & customary determination for medically necessary allowable services.

Using a PPO provider saves you money.

PRE-EXISTING CONDITIONS

A pre-existing condition is any condition or illness that existed on or before the effective date of coverage with ICHIA and for which medical treatment or advice was recommended or received within the three months before your effective date of coverage.

You qualify for a **Pre-Existing Condition Waiver** if you lost your health insurance coverage within six months from the date of your application for coverage with ICHIA and provide a Certificate of Creditable Coverage from your previous health insurer / employer.

If you do not qualify for the Pre-Existing Condition Waiver, ICHIA excludes payment of benefits for the first three months following the policy effective date for any injury or illness deemed a pre-existing condition.

If a claim is submitted that appears to be a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if any treatment or advice was given.

After the pre-existing condition waiting period of three months has been satisfied, ICHIA will cover charges related to the pre-existing condition according to your Plan's schedule of reimbursement.

You automatically receive the Pre-Existing Condition Waiver if you qualify for an ICHIA policy under the Federally Eligible eligibility category.

DEPENDENT ELIGIBILITY

Coverage for your spouse and / or children is also available. Children are eligible for coverage provided they meet one of the following requirements:

1. The dependent is unmarried and under the age of 19;
2. The dependent is unmarried and enrolled full-time at an accredited educational institution. (A dependent that meets this criteria is eligible for coverage up to age 25); or
3. The dependent is incapable of self-sustaining employment by reason of mental or physical disability and is chiefly dependent upon you for support or maintenance. (A dependent that meets this criteria is eligible for coverage beyond the age of 19.)

   The member must submit evidence that the child satisfies this requirement within 120 days of when the child reaches age 19. ICHIA may ask for evidence that the disability is continuing from time to time, but not more than once per calendar year after the two-year period following the child's attainment of age 19.

Premium rates for dependents follow the same guidelines as described in the Premium Rates section of this brochure.

NEWBORN CHILDREN

Newborn children are automatically covered for illness or injury during the first 31-days after their birth. After the initial coverage period, the newborn will have to be added to your policy as a dependent and the appropriate premium will apply.

Choose the plan that is right for you.

The Covered Benefits insert included with this brochure provides a side-by-side comparison of Plans 1, 3A and 3B with deductible, coinsurance and out-of-pocket maximums to make your decision easier.

The insert also includes exclusions to covered services.

Refer to the premium rate tables brochure for current rates to choose the plan that is right for you. Each plan has its own deductible, coinsurance, out-of-pocket maximum and level of covered benefits.

COVERED BENEFITS INCLUDE:

Inpatient Hospital Services
Mental Illness / Substance Abuse
Prescription Drugs
Professional Services
Skilled Home Health Care
Skilled Nursing Facility
Surgical Expenses
Transplant Services

PLAN 1

Deductible	$500	
Coinsurance	80% / 20%	In-Network
(no more than $1000)	60% / 40%	Out-of-Network
Out-of-Pocket Maximum	$1,500	(including deductible)

PLAN 3A

Deductible	$1,000	
Coinsurance	80% / 20%	In-Network
(no more than $2000)	60% / 40%	Out-of-Network
Out-of-Pocket Maximum	$3,000	(including deductible)

PLAN 3B

Deductible	$1,500	
Coinsurance	80% / 20%	In-Network
(no more than $2500)	60% / 40%	Out-of-Network
Out-of-Pocket Maximum	$4,000	(including deductible)

EXCLUSIONS TO COVERED SERVICES

Cosmetic Care and Related Supplies - Any services performed in connection with cosmetic surgery for a non-functional condition or for any condition that existed on the effective date of the member's coverage. ICHIA will cover: a) surgery required as a result of an injury received while insured under this policy; b) surgery for repair of congential defects of newborn children or for birth defects if the insured is under age 12 or was under age 12 when first surgically treated for that condition; c) surgery for otherwie covered medical expenses that are an integral part of such surgery; or d) surgery made necessary by previous medically necessary surgery if the insured had uninterrupted coverage with ICHIA from the date of the previous surgery.

Custodial Care - Services or treatment which, regardless of where it is provided: a) could be rendered safely by a person without medical skills; and b) is designed mainly to help the patient with daily living activities, including (but not limited to): 1) personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomyi; exercising; dressing; enema and using the toilet; 2) homemaking, such as preparing meals or special diets; 3) moving the patient; 4) acting as a companion or sitter; 5) supervising medication which can usually be self-administered; 6) oral hygiene; and 7) ordinary skin and nail care.

Dental Prosthetics and Surgery -
Dental prosthetics, Dental Services or treatment except for: a) excision of partially or completely erupted impacted teeth; b) excision of a tooth root without the extraction of the entire tooth; and c) with respect to the gums and tissues of the mouth when not performed in connection with extraction or repair of teeth.

Care or supplies received from a dental or medical department run by an employer, mutual benefit association, labor union, trust or similar person or group to the extent you have no obligation to pay for them is also excluded.

Medicaid / Medicare Charges - Charges Medicaid / Medicare paid, or for which Medicaid / Medicare would have been liable for, if the Insured had enrolled in those programs.

Experimental: The use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring federal or other government agency approval not granted at the time services were provided. The final determination as to whether one of the above items is Experimental will be made by Our designated Medical Policy Committee.

Nursing - Any kind of private duty nursing care except as described in the Home Health Care Plan.

Pre-Existing Conditions - This Policy does not pay benefits for the first three months following the Effective Date for any Pre-existing Condition. This Pre-existing Condition limit does not apply to Federally Eligible Individuals and to individuals who meet the requirements for a waiver of the Pre-existing Condition provision.

Personal Comfort Items - Any personal comfort item that is not considered medically necessary.

Services or Supplies - Which are not medically necessary, medically appropriate or are experimental in nature for the diagnosis or treatment of a specific illness.

A complete listing of such other exclusions is set out in the policy.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

Covered Benefits

COVERED BENEFITS

	PLAN 1	PLAN 1	PLAN 3A	PLAN 3A and 3B	PLAN 3B
DEDUCTIBLE	$500	The portion of health care expenses the member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins.	$1,000	The portion of health care expenses the member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins.	$1,500
COINSURANCE In-Network Out-of-Network	20% 40%	A set percentage of the cost of covered services that are an out-of-pocket payment. The amount of coinsurance differs for in-network and out-of-network service.	20% 40%	A set percentage of the cost of covered services that are an out-of-pocket payment. The amount of coinsurance differs for in-network and out-of-network service.	20% 40%
OUT-OF-POCKET MAXIMUM **(including deductible and coinsurance)**	$1,500	A limit is placed on how much the member's share of eligible expenses is per calendar year (deductible + coinsurance) before ICHIA pays 100% of eligible expenses for the remainder of the calendar year.	$3,000	A limit is placed on how much the member's share of eligible expenses is per calendar year (deductible + coinsurance) before ICHIA pays 100% of the eligible expenses for the remainder of the calendar year. Does NOT include Mental Illness and Substance Abuse or Prescription Drugs.	$4,000
Benefit	**Member Cost** In-Network / Out-of-Network	**Summary of Benefits (after deductible)**	**Member Cost** In-Network / Out-of-Network	**Summary of Benefits (after deductible)**	**Member Cost** In-Network / Out-of-Network
INPATIENT HOSPITAL SERVICES	20% / 40%	Services up to 180 days per calendar year paid at a semi-private room rate unless a private room is medically necessary.	20% / 40%	Services up to 365 days per calendar year paid at a semi-private room rate unless a private room is medically necessary.	20% / 40%
MENTAL ILLNESS / SUBSTANCE ABUSE	20% / 40%	**Outpatient**: 20 outpatient vists/year combined. **Inpatient:** Services covered in the same manner as any other illness.	20% / 40%	$50,000 lifetime benefit for mental illess and substance abuse combined. **MENTAL ILLNESS: Inpatient -** 60 days/year | **Outpatient** - 50 visits/year @ $20/visit **SUBSTANCE ABUSE: Inpatient -** 30 days/consecutive 365-day period. No more than two such 30-day periods during contract lifetime. | **Outpatient** - 60 visits/lifetime	20% / 40%
PRESCRIPTION DRUGS **DEDUCTIBLE FOR PRESCRIPTIONS ONLY** **30-day Supply (Retail location)** **90-day Supply (Mail Order)**	$300	Medco Health administers the prescription drug benefit. Retail Location (*) / Mail Order (****) $12 Generic / $30 Generic $24 Formulary / $50 Formulary $40 Non-Formulary / $90 Non-Formulary	$200	Medco Health administers the prescription drug benefits. Deductible for prescriptions. Retail Location (*) / Mail Order (****) $12 Generic / $30 Generic $24 Formulary / $50 Formulary $40 Non-Formulary / $90 Non-Formulary	$300
PROFESSIONAL SERVICES	20% / 40%	Services rendered by a physician for the treatment of a medical condition.	20% / 40%	Services rendered by a physician for the treatment of a medical condition.	20% / 40%
SKILLED HOME HEALTH CARE **Includes Home Infusion Therapy**	20% / 40%	Services for 270 visits each calendar year (as described in the policy), but may not exceed $150 for each day. ICHIA does not cover Custodial Care. Precertification applies to home infusion therapy.	20% / 40%	Services as described for 270 visits each calendar year but may not exceed $60 for each day. ICHIA does not cover Custodial Care. Precertification applies to home infusion therapy.	20% / 40%
SKILLED NURSING FACILITY	20% / 40%	As an alternative to hospital confinement, your provider may prescribe admission to a skilled nursing facility. Services up to 180 days per calendar year are covered provided confinement meets the criteria outlined in the policy. Precertification is required.	20% / 40%	As an alternative to hospital confinement, your provider may prescribe admission to a skilled nursing facility. Services up to 180 days per calendar year are covered, provided confinement meets the criteria outlined in the policy. Precertification is required.	20% / 40%
SURGICAL EXPENSES	20% / 40%	Second Surgical Opinion is elective. Plan will pay 100% of the usual and customary allowance for the second opinion.	20% / 40%	Second Surgical Opinion is mandatory on certain surgical procedures that involve overnight hospitalization. The second opinion must confirm that surgery is medically necessary before benefits will be paid. Plan will pay 100% of the usual and customary allowance for the second surgical opinion (including x-ray & laboratory services). Deductible does not apply.	20% / 40%
TRANSPLANT SERVICES	20% / 40%	Transplant services are covered without a benefit limit.	20% / 40%	Benefits are limited to $100,000 during lifetime, including payments made on your behalf to donors. ICHIA will pay eligible expenses as any other sickness and the donor's eligible expenses as if the expense was incurred by you; this includes both pre- and post-transplant expenses.	20% / 40%

(*) Retail pharmacy providers will only be paid an amount equal to the Mail Order price. If the Retail pharmacy will not accept that amount as full payment, the ICHIA Insured will be responsible for the remainder of the charge.
(**) Formulary – Please contact Medco Health at 1.800.818.0093 for a listing of the formulary drugs.
(***) Non Formulary drugs are those brand drugs that are not included in the Formulary listing.
(****) **Mail Order is mandatory after two refills of a prescription.**

(*) Retail pharmacy providers will only be paid an amount equal to the Mail Order price. If the Retail pharmacy will not accept that amount as full payment, the ICHIA Insured will be responsible for the remainder of the charge.
(**) Formulary – Please contact Medco Health at 1.800.818.0093 for a listing of the formulary drugs.
(***) Non Formulary drugs are those brand drugs that are not included in the Formulary listing.
(****) **Mail Order is mandatory after two refills of a prescription.**

INDIANA COMPREHENSIVE HEALTH

INSURANCE ASSOCIATION

AMENDMENT I

ICHIA POLICY # REV. 07-03

This **Amendment I** modifies the ICHIA Policy Rev. 07-03. It incorporates a temporary change made to the Indiana Comprehensive Health Insurance Association (ICHIA) program by the Indiana Legislature effective July 1, 2003. The Policy Rev. 07-03 is hereby amended to establish the following provisions.

I. In Network Providers [PPO] Temporarily Suspended

Beginning on July 1, 2003 and ending on the earlier of when ICHIA would be granted approval of a Medicaid add –on payment program or March 15, 2004; the reimbursement rate for Covered Services provided to ICHIA Insured's by Out-of-Network Providers will be the same as the rate paid to In Network Providers.

II. Coinsurance difference between In Network and Out-Of-Network Providers Temporarily Suspended

During the period set out in section I, the Insured under an ICHIA Policy may use any provider they choose and there will be no Out–Of –Network Coinsurance penalty imposed. The ICHIA Insured will be responsible for a 20% Coinsurance regardless of which Provider they utilize for Covered Services. This Coinsurance amount continues to be in addition to any Deductible and Copay required under the Insured's Plan.

III Reimbursement Rate for Providers Temporarily modified

During the period set out in section I, the reimbursement for Covered Services provided to ICHIA Insured's will be the rate allowed under the federal Medicare Program plus 10%.

This **Amendment I** to the Indiana Comprehensive Health Insurance Association Policy Rev. 07-03 is limited to the extent of these provisions only. In all other regards the Policy Rev. 07-03 continues in full force and effect. The Amendment becomes effective upon its approval by the Indiana Department of Insurance and its distribution to the participants in the ICHIA program

Submitted for approval of the Indiana Department of Insurance this 12th day of August, 2003.

/S/ Dennis Casey	/S/ Michelle Rice
Chairman of the Board	Secretary

INDIANA COMPREHENSIVE HEALTH

INSURANCE ASSOCIATION

AMENDMENT II

ICHIA POLICY # REV. 07-03

This **Amendment II** modifies the ICHIA Policy Rev. 07-03. It incorporates a change made to the Indiana Comprehensive Health Insurance Association (ICHIA) program by the action of the Board of Directors in implementing the Indiana Legislature enactments effective July 1, 2003. The Policy Rev. 07-03 is hereby amended to establish the following provisions.

I. Changes to the Prescription Drug Benefit

The Prescription Drug Benefit for the ICHIA Plans are amended as of October 1, 2003 to provide as follows:

The ICHIA Insured pays a **Deductible** according to the Plan design they have chosen. Those deductible amounts are designated below.

Plan 1	$300
2A & 2B	$200
2C & 3A	$200
3B & 3C	$300

After meeting that deductible, the Insured pays the following **Copays** at the purchase location indicated:

RETAIL location (*):
- $12 - Generic
- $24 – Formulary (**)
- $40 - Non Formulary (***)

MAIL ORDER (****):
- $30 - Generic
- $50 - Formulary
- $90 - Non Formulary

(*) Retail pharmacy providers will only be paid an amount equal to the Mail Order price. If the Retail pharmacy will not accept that amount as full payment, the ICHIA Insured will be responsible for the remainder of the charge.

(**) Formulary – Please contact Medco Health for a listing of the formulary drugs. They can be reached at 1.800.818.0093 or at their website at www.medcohealth.com.

(***) Non Formulary drugs are those brand drugs that are not included in the Formulary listing.

(****) Mail Order is mandatory after two refills of a prescription. The Insured is then required to order maintenance drugs through the Medco Health Mail Order pharmacy. When you order by mail order, you will receive a 90 day supply.

This **Amendment II** to the Indiana Comprehensive Health Insurance Association Policy Rev. 07-03 is limited to the extent of these provisions only. In all other regards the Policy Rev. 07-03, as previously amended, continues in full force and effect. The Amendment becomes effective upon its approval by the Indiana Department of Insurance and its distribution to the participants in the ICHIA program.

Submitted for approval of the Indiana Department of Insurance this 19th day of August, 2003.

/S/ Dennis Casey	/S/ Michelle Rice
Chairman of the Board	Secretary

Indiana Comprehensive Health Insurance Association

P. O. Box 33730
Indianapolis, Indiana 46203-0730
317-614-2133
1-800-552-7921
www.online-Healthplan.com®

Please note that your final eligibility will be determined by Indiana Comprehensive Health Insurance Association (ICHIA) in accordance with the statute listed.

IC 27-8-10-10 Sec. 10.

Before January 1, 1996, the board of directors of the association shall establish eligibility guidelines for the issuance of an association policy under this chapter to prohibit an:

(1) employer
(2) insurance agent; or
(3) insurance broker;

from placing in or referring to the association an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002).

Declination by the employer's carrier does not guarantee eligibility for ICHIA.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

PHARMACY PRESCRIPTION SERVICE

Effective 10-1-03

Plan I You have a separate deductible of $300 per calendar year for your prescriptions. After this deductible has been met, you will pay a copayment of $12 for generic, $24 for formulary** and $40 for non formulary*** for your **first two** refills at your retail pharmacy*. After these initial refills, you would be **required** to order any maintenance drug through your mail order provider. Mail order would provide a **90 day supply** for $30 generic, $50 formulary and $90 non formulary.

Plan 3A You have a separate deductible of $200.00 per calendar year for your prescriptions. After this deductible has been met, you will pay a copayment of $12 for generic, $24 for formulary** and $40 for non formulary*** for your **first two** refills at your retail pharmacy*. After these initial refills, you would be **required** to order any maintenance drug through your mail order provider. Mail order would provide a **90 day supply** for $30 generic, $50 formulary and $90 non formulary

Plan 3B You have a separate deductible of $300.00 per calendar year for your prescriptions. After this deductible has been met, you will pay a copayment of $12 for generic, $24 for formulary** and $40 for non formulary*** for your **first two** refills at your retail pharmacy*. After these initial refills, you would be **required** to order any maintenance drug through your mail order provider. Mail order would provide a **90 day supply** for $30 generic, $50 formulary and $90 non formulary

(*) Retail pharmacy providers will only be paid an amount equal to the Mail Order price. If the Retail pharmacy will not accept that amount as full payment, the ICHIA Insured will be responsible for the remainder of the charge.

(**) Formulary – Please contact Medco Health for a listing of the formulary drugs. They can be reached at 1.800.818.0093 or at their website at www.medcohealth.com.

(***) Non Formulary drugs are those brand drugs that are not included in the Formulary listing.

(****) Mail Order is mandatory after two refills of a prescription. The Insured is then required to order maintenance drugs through their mail order provider. ICHIA contracts with Medco Health as the primary mail order provider. When you order by mail order, you will receive a 90 day supply.

INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

P.O. Box 33730
Indianapolis, IN 46203-0730
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www.online-Healthplan.com®

Dear Prospective Member:

Thank you for your interest in health care coverage offered by Indiana Comprehensive Health Insurance Association (ICHIA).

In order to serve you effectively, please complete the checklist below prior to mailing your application. The checklist will ensure we receive all of the necessary information needed to process your application.

- ❍ Is your application completely filled out and signed in **black** ink?
- ❍ Did you choose a health care plan (Plan 1, 3A or 3B)? **See Section I.**
- ❍ Did you specify an effective date? If not, the effective date will be the date a complete and accurate application was approved. **See Section I.**
- ❍ If you have a post office box, is a street address also included? We must have a street address in order to prove residency. **See Section II.**
- ❍ If you listed dependents, do they meet the eligibility requirements listed? Have you included proof of dependency? **See Section III.**
- ❍ Have you included proof of Indiana residency (for at least 12 months)? If a driver's license is used as proof of residency, it must be issued at least 12 months prior to the date of your application. If you are federally eligible under HIPAA, you are only required to meet the proof of current residency. **See Section IV.**
- ❍ Did you check an eligibility category? Did you include a copy of the documentation asked for under the category you checked? **See Section IV.**
- ❍ Did you identify any other health care coverage for which you or your spouse is eligible? **See Section V.**
- ❍ Did you complete and include the Medicaid Application Verification Form? If you are federally eligible, it is not required that you apply to Medicaid. **See Section V.**
- ❍ Have you individually listed ALL medical advice, care or treatment you received in the three months preceding your application? **See Section VII.**
- ❍ If the Pre-Existing Waiver Benefit applied to you, did you include a Certificate of Creditable Coverage from your previous insurance carrier / employer? **See Section VII.**
- ❍ Did you provide gross income and number of family members? **See Section VIII.**
- ❍ Did you sign the Disclosure Authorization and Declaration? **See Section IX**
- ❍ Did you identify a premium payment cycle (Monthly, Monthly Bank Draft, Monthly Credit Card, or Quarterly? **See Section X.**
- ❍ Have you included the premium payment due according to the payment cycle chosen (monthly payment cycle requires an initial three months of premium)? **See Section X.**
- ❍ If you chose the Monthly Bank Draft premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check? **See Section X.**
- ❍ If you chose the Credit Card premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Credit Card Withdrawal? **See Section X.**

Your application should be processed within 10 business days from the date of receipt if all necessary information is included.

APPLICATION FOR COVERAGE

INDIANA COMPREHENSIVE HEALTH INSURANCE PLAN (ICHIA)

POLICY ADMINISTERED BY:
ACS Healthcare Solutions (ACS)

P.O. Box 33730
Indianapolis, IN 46203-0730
1-800.552.7921 OR
317.614.2133
www.online-Healthplan.com®

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, log onto our **web site** at **www.onlinehealthplan.com** or call **customer service** at **1.800.552.7921**.

SECTION I: PLAN INFORMATION

FOR OFFICE USE ONLY

EFFECTIVE DATE OF COVERAGE: ____ ____ ____

Please choose one: I understand once eligibility is verified, the effective date of coverage will be the later of: 1) the date application is approved, 2) the day after your previous major medical coverage ends or 3) the following date as requested _____. (Requested date must be a future date not exceeding 60 days.)

A

- ☐ **PLAN 1** ($500 DEDUCTIBLE and $1,000 COINSURANCE = $1,500 OUT-OF-POCKET MAXIMUM)
- ☐ **PLAN 3A** ($1,000 DEDUCTIBLE and $2,000 COINSURANCE = $3,000 OUT-OF-POCKET MAXIMUM)
- ☐ **PLAN 3B** ($1,500 DEDUCTIBLE and $2,500 COINSURANCE = $4,000 OUT-OF-POCKET MAXIMUM)

Please Note: In the future, you may only elect to change a Plan to one with a HIGHER deductible. This change will take effect on the following January 1st only.

SECTION II: APPLICANT INFORMATION

E-MAIL ADDRESS (optional)

B

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

STREET ADDRESS (Mandatory)	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
	☐ Male ☐ Female	/ /	

CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE

HOME TELEPHONE	WORK TELEPHONE	CUSTODIAL PARENT / GUARDIAN IF APPLICANT IS A MINOR	SOCIAL SECURITY NUMBER
( )	( )		– –

SECTION III: DEPENDENT / SPOUSE INFORMATION

List dependents (including spouse) to be covered under this plan. Dependents must be (1) unmarried and under the age of 19, (2) unmarried, under the age of 25, a full-time student at an accredited high school, trade school, college or university, and chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental retardation or mental or physical disability, and chiefly dependent upon you for support. Proof may be required.

C

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

D

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

E

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

F

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

SECTION IV: ELIGIBILITY INFORMATION

PLEASE CHECK AND INITIAL EACH ELIGIBILITY CATEGORY FOR WHICH YOU ARE APPLYING

G Each Eligibility Category **REQUIRES ONE** of the following Documentary Proofs of Residency:

1) **PROOF OF CURRENT RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt within 3 months prior to the date of the application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period; a copy of your active Indiana driver's license **OR** a copy of your active Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles; or
2) **PROOF OF 12 MONTH RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt 12 months prior to date of application **AND** another receipt within the last 3 months prior to the date of application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period, a copy of your Indiana driver's license issued at least 12 months ago **OR** a copy of your Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles dated 12 months or more prior to the date of application for ICHIA.

I CERTIFY that I am eligible for coverage because:

✓ **(Please check the eligibility category you are applying under)**

G-1 ☐ FEDERALLY ELIGIBLE

I am federally eligible according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 because I have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage of at least 63 days. My most recent coverage was under a group plan and I have exhausted my benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). I am not eligible under another group health plan offered by my employer or as a dependent for coverage through my spouse, parent or guardian; my most recent coverage was not cancelled because I failed to pay my premiums, failed to pay my premiums in a timely manner or committed fraud; I am not eligible for Medicaid; and I did not accept a conversion policy or a short-term limited duration policy after my group, COBRA or state continuation coverage ended.

Name of the organization that provided your last month of coverage:_____

(month/date/year)

The date you terminated from the organization that provided your last month of coverage:_____/_____/_____

Reason for termination of coverage: ☐ Failure to pay premiums ☐ For Fraudulent Reasons ☐ Other (Explain) _____

_____

Did your former employer sponsor a health insurance plan for any of its employees? ☐ YES ☐ NO

Which of the following types of organizations was your former employer? ☐ Company ☐ Governmental Entity ☐ Church ☐ Other (Explain)_____

At the time you terminated employment with your former employer, did your former employer offer you an opportunity to continue your group insurance coverage (with you paying the premium) under COBRA or state continuation coverage? ☐ YES ☐ NO

During the past 21 months, have you accepted conversion or short-term limited duration coverage? ☐ YES ☐ NO

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the **Certificate of Health Plan Coverage** provided by your previous insurance carrier / employer or other evidence of medical coverage.
2) **Documentary PROOF OF CURRENT RESIDENCY** in the state of Indiana (See Section G for required documentation).

_____**Initial Here**

G-2 ☐ REJECTION FOR OTHER HEALTH COVERAGE

I received notification of rejection from one health insurer from individual health insurance coverage substantially similar to the coverage offered by ICHIA.

Date your last health coverage ended: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the letter of rejection from health insurer that is dated within 90 days of the date on the application. ☐ YES ☐ NO
2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section G for required documentation).

_____**Initial Here**

G-3 ☐ PREMIUM RATE HIGHER THAN ICHIA

I am currently on an individual policy and am not eligible for any coverage that equals or exceeds the minimum requirements for Accident and Sickness policies in Indiana. I received a recent premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) **A copy of the premium notice and deductible for the policy** must accompany your application.
2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section G for required documentation).

_____**Initial Here**

SECTION V: OTHER HEALTH CARE COVERAGE

H ☐ YES ☐ NO Do you or any person named on this application have any other **medical or hospital insurance in effect or for which you are eligible?**

If **YES**: Name of person(s): _____ _____

Insurance Company Name: _____ _____

Insurance Company Phone: _____ _____

TYPE OF COVERAGE:

Is your current coverage GROUP? ☐ YES ☐ NO

The date you terminated or will be terminated from the organization that is providing your group coverage: (month/date/year) ___/___/_____

Are you currently covered by COBRA or state continuation coverage? ☐ YES ☐ NO

If YES, and if you are approved for coverage with ICHIA, how many months will you have been on COBRA or state continuation coverage by the time you start coverage with ICHIA?_____

Is your current coverage INDIVIDUAL? ☐ YES ☐ NO

If YES, check the box that best describes your coverage:

☐ Comprehensive Major Medical (CMM) ☐ Limited benefit (e.g., "hospital-only" coverage or "cancer-only" coverage, etc.)

☐ Union plan ☐ Professional or trade association plan ☐ Student health plan

☐ Another state health benefits risk pool (a plan like ICHIA)

☐ Medicare (disabled) under age 65 ☐ Medicare over age 65

☐ Other (Explain):_____

Is it your intent to replace your current coverage with ICHIA coverage? ☐ YES ☐ NO

If **YES**, please explain the reason for replacement:_____

If **NO**: Does your current employer offer health coverage to any of its employees? ☐ YES ☐ NO

If **YES**, has your employer offered you an opportunity to participate in the employer-sponsored health plan? ☐ YES ☐ NO

If YES, why aren't you participating in the employer-sponsored plan?

☐ I have waived my employer-sponsored coverage

☐ I have been directed or encouraged to apply for _____ (Please explain under "Other" above.)

Based on Indiana Law, effective July 1, 2003 all ICHIA applicants must apply for Medicaid within 60 days prior to applying to ICHIA. **You must provide a copy of your completed application to Medicaid with your ICHIA application**.

If it is determined you are eligible for Medicaid after you are approved for ICHIA, your ICHIA coverage will be terminated the date ICHIA obtained notification. Your coverage will not be terminated retroactively. Medical and pharmacy claims will be revoked and refunds requested. Have you enclosed the completed Medicaid Verification Form? _____(check here)

SECTION VI: PREMIUM PROVISION

I Will any **PART** or ALL of the premium used to purchase this coverage be provided by:

A church / church affiliated group ☐ YES ☐ NO

A division of government, either county, city, state, federal or other? ☐ YES ☐ NO

A government agency, such as Medicaid, Medicare, public health department or other programs such as indigent programs? ☐ YES ☐ NO

A public or private foundation? ☐ YES ☐ NO

A health care provider? ☐ YES ☐ NO

An employer of the individual? ☐ YES ☐ NO

A person other than the individual's parent, adult child or guardian? ☐ YES ☐ NO

Other _____ (please explain) ☐ YES ☐ NO

If you answered "YES" to any question above, please list the following:

Name of organization: _____

Address of organization: _____

_____

Phone number of organization: _____

SECTION VII: PRE-EXISTING CONDITIONS PROVISION

J Benefits under any ICHIA policy (including spouse / dependent) will not be payable for a pre-existing condition (injury or sickness) for the first three months following the effective date of coverage if medical advice or treatment for the pre-existing injury or sickness was recommended or received within a period of three months before the effective date of coverage.

☐ **YES** ☐ **NO** Have you been diagnosed, treated or sought any medical advice or examination within the 3 months? If so, explain:

_____

☐ **YES** ☐ **NO** Have you had any major medical coverage in the last six months?

WAIVER BENEFIT (automatic for federally eligible individuals): You and any person named on this application may be eligible for a waiver of the pre-existing condition wait period if you lost your health insurance coverage within the last six months. **A copy of the Certificate of Health Plan Coverage provided by your previous health insurance carrier / employer or other evidence of medical coverage must be sent along with this application**.

PLEASE ANSWER THE FOLLOWING QUESTION:

☐ **YES** ☐ **NO** Have you or any person named on this application received medical advice, care or treatment, including any prescription medications in the six months preceding the effective date of coverage?

If **YES**, please provide **Medical Information** for each person named above (attach an additional sheet of paper if necessary).

APPLICANT NAME	PHYSICIAN NAME	DIAGNOSIS	TREATMENT and/or MEDICATION	DATES OF TREATMENT	DATES OF HOSPITALIZATION

SECTION VIII: INCOME INFORMATION

ICHIA is required to gather information on your family income as of the date of this application. Please fill in the information below.

Number in family _____

Annual Gross Income _____

ICHIA reserves the right to request supporting documentation including copies of your most recent income taxes filed.

SECTION IX: DISCLOSURE AUTHORIZATION AND DECLARATION

The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed.

I understand and agree that referring agents are not authorized to interpret, amend or alter the terms of the ICHIA policy, nor are referring agents authorized to bind ICHIA in any way.

I permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization, or other health plan provider to give ICHIA, the Administrator, or its designated representative any medical information about me or my dependents, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate my eligibility for an ICHIA policy and claims for benefits and determine continued eligibilty in the future. I further authorize the Administrator, if necessary, to contact my employer or my spouse's employer about prior insurance coverage. A reproduction of this authorization shall be as valid as the original.

The information provided on this form and any attachments is private data under Indiana law. By providing this data, I authorize ICHIA and its Administrator to use and disclose the data as follows. The law does not require me to provide any data, but failure to do so will result in loss of eligibility for ICHIA. Any data provided may be made available to the agents, directors or officers of ICHIA, the Administrator or legal counsel. The data may also be made available to provider peer review panels or consultants, the actuarial or research organizations, or other persons authorized by law to receive such data.

I have read the above statement, and I agree to supply the data throughout this application with full knowledge of the information provided in the statement.

K SIGNATURE OF APPLICANT	DATE OF APPLICATION (MONTH / DAY / YEAR) / /

L SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (if applicant is under age 18)	DATE: (MONTH / DAY / YEAR) / /

SECTION X: RESEARCH AUTHORIZATION

Under limited circumstances, ICHIA may use or share some medical information of its participants for the purpose of research and research-related studies. The information used or shared will not individually identify any participant and will meet all privacy law requirements in effect at the time.

M SIGNATURE OF APPLICANT

DATE OF APPLICATION (MONTH / DAY / YEAR) / /

N SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (if applicant is under age 18)

DATE: (MONTH / DAY / YEAR) / /

SECTION XI: PREMIUM PAYMENT

O **PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:**

☐ **MONTHLY** - 3 MONTHS PREMIUM DUE WITH APPLICATION.

☐ **QUARTERLY** - 3 MONTHS PREMIUM DUE WITH APPLICATION.

PAYMENT METHOD SELECTION

☐ **I have enclosed a CHECK in the amount of $_____.**

☐ **I will continue to pay by CHECK the premium payment option I have chosen above.**

- OR -

☐ **I would like my premium payment withdrawn automatically every month from my checking account. I have completed the Authorization Agreement for Automatic Withdrawal.**

- OR -

☐ **I would like future payments withdrawn from my credit card. I UNDERSTAND THAT MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.**

☐ **Please bill my CREDIT CARD based on the option I have chosen above. I have completed the Authorization Agreement for Automatic Credit Card Withdrawal.**

☐ **I will continue to pay by CREDIT CARD. I UNDERSTAND THAT AFTER THE INITIAL PREMIUM PAYMENT IS DRAWN ON MY CREDIT CARD, IF I CHOOSE TO CONTINUE BY CREDIT CARD, MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.**

- OR -

☐ **I would like my premium payment withdrawn automatically every month from my checking account. I have completed the Authorization Agreement for Automatic Withdrawal.**

- OR -

☐ **I will make premium payments by check based on the premium payment option I have chosen above.**

IF YOU ELECT TO PAY YOUR PREMIUM BY CHECK AND NO PREMIUM IS RECEIVED WITH THE APPLICATION, YOUR APPLICATION WILL BE REJECTED.

P **USE THE PREMIUM RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT:**

RATE AREA YOUR RESIDENCE IS IN:

PREMIUM AMOUNT ENCLOSED → $

FOR OFFICE USE ONLY

$, . | PREMIUM PAYMENT | CHECK NUMBER

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for members who are on a **monthly premium payment cycle**. Your premiums can be automatically withdrawn from your checking account on a monthly basis.

The withdrawal is done on the 1st Friday of each month in the bank's nightly cycle. (If the 1st Friday of the month falls on the 1st, 2nd or 3rd day of the month, the withdrawal takes place on the 2nd Friday of the month).

To have your premium payment automatically withdrawn from your checking account each month:

1. Complete the **Authorization Agreement** below.
2. Verify your **Account Number** and **Routing Number** with your financial institution (frequently, the account number listed on your check includes digits that are not actually part of the account number).
3. Send a copy of a **Voided Check** with your application.

(detach here)

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL

I hereby request and authorize the Financial Institution named below to pay and charge to my account checks / drafts drawn on my account by and payable to the order of Indiana Comprehensive Health Insurance Association (ICHIA) provided there are sufficient collected funds in my account to pay such checks / drafts upon presentation. I agree that your rights in respect to each such check / draft shall be the same as if it were a check / draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check / draft.

I further agree that if any such check / draft is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive 15 days written notice from me of its revocation.

BANKING INFORMATION

NAME OF INSURED (APPLICANT)		NAME OF JOINT ACCOUNT HOLDER	
NAME OF FINANCIAL INSTITUTION			TYPE OF ACCOUNT ☐ Checking ☐ Savings
FINANCIAL INSTITUTION ADDRESS			ACCOUNT NUMBER
CITY	STATE	ZIP CODE	ROUTING NUMBER

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)	NAME OF JOINT ACCOUNT HOLDER (please print)
SIGNATURE	SIGNATURE
DATE (mm / dd / yy) / /	DATE (mm / dd / yy) / /

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized checks / drafts drawn against depositors of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks / drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks / drafts. We shall defend any action brought against you by any of your depositors or any other person because of your compliance with the pre-authorized check / draft plan.

CHIA-002 rev. 1-2-04

AUTHORIZATION AGREEMENT FOR MONTHLY CREDIT CARD WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for members who are on a **monthly premium payment cycle**. Your premiums can be automatically withdrawn from your credit card account on a monthly basis.

The withdrawal from your credit card is done on the 15th of the month for the next month's coverage period with the exception of your initial withrawal which **will be for 3 months**. If the 15th falls on a weekend or holiday, the withdrawal will be done on the next business day.

To have your premium payment automatically withdrawn from your credit card account each month:

1. Complete the **Credit Card Authorization Agreement** below.
2. Verify your **Account Number**
3. **NOTE**: This form must be 100% filled out in order to do the withdrawal. If any part is not completed, the **entire form will have to be done over.**

(detach here)

CREDIT CARD WITHDRAWAL AUTHORIZATION AGREEMENT

I hereby request and authorize Indiana Comprehensive Health Insurance Association (ICHIA) to automatically withdraw from my credit card account the amount of the monthly premium bill and applicable service and transaction fees due by me. I agree that your rights in respect to each such credit card withdrawal shall be the same as if it were a charge signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such credit card withdrawal. **NOTE: I must give 60 days written notice to stop or change this authorization. ICHIA will not refund any transaction fees or interest fees. ICHIA will not be held liable for any interest charges incurred by my credit card company unless an error is a direct result of ICHIA.**

I further agree that if any such credit card withdrawal is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive **60 days written notice** from me of its revocation.

NOTE TO DEBIT CARD HOLDERS: You may wish to use the EFT option to avoid the Visa / MasterCard transaction fees.

CREDIT CARD INFORMATION

ALL BLOCKS MUST BE 100% FILLED IN OR YOU WILL HAVE TO FILL OUT ANOTHER FORM IN ITS ENTIRETY

NAME OF CARD HOLDER	NAME OF INSURED (IF DIFFERENT THAN CARD HOLDER)S	TYPE OF CREDIT CARD ☐ Visa ☐ MasterCard
CARD HOLDER ADDRESS	CREDIT CARD NUMBER **(You must include the CVV2 number**.This is a 3-digit number at the end of your credit card number located in the printed version of the number on the back of the card.) EXPIRATION DATE _____ / _____	
CITY / STATE / ZIP CODE		How to Calculate Your Credit Card Charge: $_____ **Monthly** Premium Amount x _____ % 2.17% Visa / MasterCard Fee + $3.00 Transaction Fee
TOTAL CREDIT CARD CHARGE TO BE WITHDRAWN: This withdrawal will be taken on the 15th of each month for the next coverage period		

* This premium is subject to change based on the member's birthday due to the rate differentials by age and periodic ICHIA rate changes.

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)	NAME OF JOINT ACCOUNT HOLDER (please print)
SIGNATURE	SIGNATURE
DATE (mm / dd / yy) / /	DATE (mm / dd / yy) / /

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized credit card withdrawals against card owners of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such credit card withdrawals, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such credit card withdrawals. We shall defend any action brought against you by any of your credit card owners or any other person because of your compliance with the pre-authorized credit card withdrawal plan.

Indiana Comprehensive Health Insurance Association

P. O. Box 33730
Indianapolis, Indiana 46203-0730
317-614-2133
1-800-552-7921

MEDICAID APPLICATION VERIFICATION FORM

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

This will hereby verify that _____(Applicant) has made application with the Indiana Medicaid Program through the Medicaid office located at_____ on the date of _____.

AUTHORIZED MEDICAID REPRESENTATIVE NAME (print) _____

AUTHORIZED MEDICAID REPRESENTATIVE SIGNATURE _____

PHONE NUMBER OF MEDICAID REPRESENTATIVE _____

APPLICANT SECTION:

I, _____ (applicant), by signing this form, am verifying to the Indiana Comprehensive Health Insurance Association (ICHIA) that I have made application to the Indiana Medicaid Program on _____ (date). Furthermore, I will advise ICHIA immediately upon receipt of my acceptance or rejection notice to the Indiana Medicaid Program.

PRINTED NAME OF APPLICANT:_____

SIGNATURE OF APPLICANT: _____

IF APPLICANT IS A MINOR, PRINTED NAME OF LEGAL GUARDIAN:

_____

IF APPLICANT IS A MINOR, SIGNATURE OF LEGAL GUARDIAN:

_____

DATE OF SIGNATURE: _____

Follow these easy steps to determine what your rates will be.

1. Find your county on the next panel to determine your area.

2. Locate the mode of payment that's best for you — annually, semi-annually, quarterly, or monthly.*

3. Choose the plan that best suits you:

Plan 1 — $500 deductible

Plan 3A — $1000 deductible

Plan 3B — $1500 deductible

4. Find the proper age bracket for each insured.

5. Within your correct category, determine what your premium will be.

*** Monthly option requires 3 months advanced payment with application.**

AREA 1

Adams	Jay	Putnam
Bartholomew	Jefferson	Randolph
Blackford	Jennings	Ripley
Brown	Knox	Saint Joseph
Clay	Kosciusko	Scott
Crawford	Lagrange	Spencer
Daviess	Lawrence	Starke
Decatur	Marshall	Steuben
DeKalb	Martin	Sullivan
Dubois	Monroe	Switzerland
Elkhart	Montgomery	Union
Fayette	Noble	Vermillion
Franklin	Ohio	Vigo
Greene	Orange	Washington
Harrison	Owen	Wayne
Henry	Parke	Wells
Huntington	Perry	Whitley
Jackson	Pike	

AREA 2

Allen	Fulton	Morgan
Benton	Gibson	Newton
Boone	Grant	Pulaski
Carroll	Hamilton	Rush
Cass	Hancock	Shelby
Clark	Hendricks	Tippecanoe
Clinton	Howard	Tipton
Dearborn	Jasper	Wabash
Delaware	Johnson	Warren
Floyd	Madison	White
Fountain	Miami	

AREA 3

LaPorte	Posey	Warrick

AREA 4

Lake	Porter

AREA 5

Marion	Vanderburgh

PREMIUM RATE TABLES

Indiana Comprehensive Health Insurance Association

Effective October 1, 2003

IMPORTANT

Information contained in this rate card is subject to change without notice. To verify information contained in this rate card, please contact the administrator prior to application.

ICHIA-012 (8/03)
Revised layout 7-03

MONTHLY

RATE AREA 1

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$218.62	$249.86	$169.23	$193.03	$115.48	$131.22
19 - 24	275.17	547.57	223.55	444.32	182.81	361.21
25 - 29	281.96	547.57	230.62	444.32	188.82	361.21
30 - 34	307.49	547.57	251.81	444.32	206.05	361.21
35 - 39	344.48	547.57	281.36	444.32	228.87	361.21
40 - 44	410.58	547.57	335.60	447.84	272.69	363.15
45 - 49	505.78	601.20	414.84	490.33	337.43	396.32
50 - 54	625.76	687.47	515.48	560.52	420.39	452.42
55 - 59	785.34	797.00	649.30	650.89	530.86	526.30
60 - 64	951.13	942.54	786.32	770.44	642.23	623.49
65 +	1,104.66	1,089.67	908.89	886.94	738.54	714.60

RATE AREA 2

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$231.19	$264.22	$178.95	$204.12	$122.12	$138.76
19 - 24	290.98	579.04	236.39	469.85	193.31	381.97
25 - 29	298.17	579.04	243.87	469.85	199.68	381.97
30 - 34	325.16	579.04	266.28	469.85	217.89	381.97
35 - 39	364.27	579.04	297.53	469.85	242.03	381.97
40 - 44	434.17	579.04	354.89	473.58	288.36	384.02
45 - 49	534.85	635.75	438.68	518.51	356.82	419.10
50 - 54	661.72	726.98	545.11	592.73	444.55	478.42
55 - 59	830.47	842.80	686.61	688.30	561.37	556.55
60 - 64	1,005.79	996.71	831.51	814.72	679.14	659.32
65 +	1,168.15	1,152.30	961.12	937.92	780.98	755.67

RATE AREA 3

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$243.75	$278.58	$188.68	$215.22	$128.75	$146.30
19 - 24	306.79	610.51	249.24	495.39	203.82	402.73
25 - 29	314.37	610.51	257.13	495.39	210.53	402.73
30 - 34	342.84	610.51	280.75	495.39	229.74	402.73
35 - 39	384.07	610.51	313.70	495.39	255.18	402.73
40 - 44	457.77	610.51	374.18	499.32	304.04	404.89
45 - 49	563.92	670.30	462.52	546.69	376.22	441.87
50 - 54	697.68	766.49	574.73	624.94	468.71	504.42
55 - 59	875.60	888.61	723.93	725.71	591.88	586.79
60 - 64	1,060.45	1,050.88	876.70	858.99	716.04	695.16
65 +	1,231.63	1,214.92	1,013.36	988.89	823.43	796.74

RATE AREA 4

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$266.37	$304.43	$206.18	$235.18	$140.70	$159.88
19 - 24	335.26	667.15	272.37	541.35	222.73	440.10
25 - 29	343.54	667.15	280.98	541.35	230.06	440.10
30 - 34	374.65	667.15	306.80	541.35	251.05	440.10
35 - 39	419.71	667.15	342.81	541.35	278.85	440.10
40 - 44	500.24	667.15	408.90	545.65	332.25	442.45
45 - 49	616.24	732.49	505.44	597.42	411.12	482.87
50 - 54	762.42	837.61	628.06	682.93	512.20	551.22
55 - 59	956.85	971.06	791.10	793.04	646.79	641.24
60 - 64	1,158.85	1,148.38	958.04	938.70	782.48	759.66
65 +	1,345.91	1,327.64	1,107.38	1,080.65	899.83	870.66

RATE AREA 5

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$251.29	$287.20	$194.51	$221.87	$132.73	$150.83
19 - 24	316.28	629.39	256.95	510.71	210.12	415.19
25 - 29	324.10	629.39	265.08	510.71	217.04	415.19
30 - 34	353.44	629.39	289.44	510.71	236.84	415.19
35 - 39	395.95	629.39	323.41	510.71	263.07	415.19
40 - 44	471.93	629.39	385.75	514.76	313.44	417.41
45 - 49	581.36	691.03	476.83	563.60	387.85	455.54
50 - 54	719.26	790.20	592.51	644.27	483.21	520.02
55 - 59	902.68	916.09	746.32	748.15	610.18	604.94
60 - 64	1,093.25	1,083.38	903.81	885.56	738.19	716.66
65 +	1,269.72	1,252.50	1,044.70	1,019.48	848.89	821.38

QUARTERLY

RATE AREA 1

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$643.72	$735.70	$498.28	$568.36	$340.02	$386.37
19 - 24	810.21	1,612.28	658.22	1,308.26	538.27	1,063.57
25 - 29	830.23	1,612.28	679.05	1,308.26	555.98	1,063.57
30 - 34	905.39	1,612.28	741.44	1,308.26	606.71	1,063.57
35 - 39	1,014.29	1,612.28	828.46	1,308.26	673.90	1,063.57
40 - 44	1,208.92	1,612.28	988.16	1,318.65	802.93	1,069.26
45 - 49	1,489.25	1,770.19	1,221.47	1,443.76	993.55	1,166.94
50 - 54	1,842.51	2,024.22	1,517.81	1,650.41	1,237.83	1,332.12
55 - 59	2,312.38	2,346.72	1,911.82	1,916.52	1,563.08	1,549.66
60 - 64	2,800.54	2,775.25	2,315.27	2,268.51	1,891.00	1,835.83
65 +	3,252.61	3,208.48	2,676.17	2,611.56	2,174.59	2,104.10

RATE AREA 2

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$680.72	$777.99	$526.92	$601.03	$359.56	$408.58
19 - 24	856.77	1,704.94	696.05	1,383.45	569.20	1,124.70
25 - 29	877.94	1,704.94	718.07	1,383.45	587.93	1,124.70
30 - 34	957.43	1,704.94	784.06	1,383.45	641.58	1,124.70
35 - 39	1,072.58	1,704.94	876.07	1,383.45	712.63	1,124.70
40 - 44	1,278.39	1,704.94	1,044.96	1,394.44	849.07	1,130.71
45 - 49	1,574.84	1,871.92	1,291.67	1,526.73	1,050.65	1,234.00
50 - 54	1,948.40	2,140.56	1,605.04	1,745.26	1,308.97	1,408.68
55 - 59	2,445.27	2,481.59	2,021.70	2,026.66	1,652.92	1,638.72
60 - 64	2,961.49	2,934.75	2,448.33	2,398.89	1,999.68	1,941.34
65 +	3,439.54	3,392.87	2,829.98	2,761.65	2,299.56	2,225.03

RATE AREA 3

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$717.71	$820.27	$555.55	$633.69	$379.10	$430.79
19 - 24	903.34	1,797.60	733.88	1,458.64	600.14	1,185.82
25 - 29	925.65	1,797.60	757.10	1,458.64	619.89	1,185.82
30 - 34	1,009.46	1,797.60	826.67	1,458.64	676.45	1,185.82
35 - 39	1,130.87	1,797.60	923.68	1,458.64	751.36	1,185.82
40 - 44	1,347.87	1,797.60	1,101.75	1,470.22	895.22	1,192.17
45 - 49	1,660.43	1,973.66	1,361.87	1,609.70	1,107.75	1,301.07
50 - 54	2,054.29	2,256.89	1,692.27	1,840.11	1,380.11	1,485.24
55 - 59	2,578.17	2,616.46	2,131.57	2,136.81	1,742.75	1,727.78
60 - 64	3,122.44	3,094.24	2,581.39	2,529.26	2,108.35	2,046.85
65 +	3,626.47	3,577.27	2,983.78	2,911.74	2,424.54	2,345.95

RATE AREA 4

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$784.30	$896.38	$607.10	$692.49	$414.28	$470.76
19 - 24	987.15	1,964.39	801.97	1,593.98	655.82	1,295.84
25 - 29	1,011.54	1,964.39	827.34	1,593.98	677.40	1,295.84
30 - 34	1,103.12	1,964.39	903.37	1,593.98	739.21	1,295.84
35 - 39	1,235.80	1,964.39	1,009.39	1,593.98	821.07	1,295.84
40 - 44	1,472.93	1,964.39	1,203.97	1,606.63	978.28	1,302.78
45 - 49	1,814.49	2,156.78	1,488.23	1,759.06	1,210.53	1,421.79
50 - 54	2,244.90	2,466.30	1,849.29	2,010.84	1,508.16	1,623.05
55 - 59	2,817.38	2,859.22	2,329.34	2,335.07	1,904.45	1,888.09
60 - 64	3,412.16	3,381.34	2,820.90	2,763.94	2,303.97	2,236.76
65 +	3,962.95	3,909.18	3,260.63	3,181.90	2,649.50	2,563.62

RATE AREA 5

Ages	PLAN 1 Male	PLAN 1 Female	PLAN 3A Male	PLAN 3A Female	PLAN 3B Male	PLAN 3B Female
Child	$739.91	$845.64	$572.74	$653.29	$390.83	$444.11
19 - 24	931.27	1,853.20	756.58	1,503.75	618.70	1,222.49
25 - 29	954.28	1,853.20	780.51	1,503.75	639.06	1,222.49
30 - 34	1,040.68	1,853.20	852.23	1,503.75	697.37	1,222.49
35 - 39	1,165.85	1,853.20	952.25	1,503.75	774.60	1,222.49
40 - 44	1,389.56	1,853.20	1,135.82	1,515.69	922.91	1,229.04
45 - 49	1,711.79	2,034.70	1,403.99	1,659.49	1,142.01	1,341.31
50 - 54	2,117.83	2,326.69	1,744.61	1,897.02	1,422.79	1,531.18
55 - 59	2,657.91	2,697.38	2,197.49	2,202.89	1,796.65	1,781.22
60 - 64	3,219.01	3,189.94	2,661.23	2,607.49	2,173.56	2,110.15
65 +	3,738.63	3,687.90	3,076.06	3,001.79	2,499.52	2,418.51

Indiana Comprehensive Health Insurance Association
NOTICE OF PRIVACY POLICY AND PRACTICES

This Notice Describes How Medical Information About You May Be Used And Disclosed, And How You Can Get Access To This Information. Please Review It Carefully. It Is Provided In Accordance With The Health Insurance Portability And Accessibility Act (HIPAA).

Indiana Comprehensive Health Insurance Association (ICHIA or the "Program") is required under HIPAA to maintain the privacy of your medical information and to provide you with a notice of its legal duties and privacy practices. The Program will not use or disclose your medical information except as described in the HIPAA law and in accordance with this Notice. This Notice applies to all of the medical information generated by the Program, as well as medical information we receive from others.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: ICHIA may use and disclose your medical information for treatment, payment and health care operations. ICHIA has outsourced many of the functions in these areas to an administrative services carrier, ACS Healthcare Solutions ("ACS" doing business in Indiana as OASYS); its disease management provider, Accordant Health Services, ("Accordant"); its care management provider, American Health Holdings ("AHH"); and the Program's pharmacy benefit manager, Systemed. ICHIA also has an agreement with Anthem Insurance Companies to provide some services on behalf of the Program. When acting on behalf of ICHIA, each of these entities is considered a business associate of the Program, and is required to protect and maintain the privacy of your medical information in the same manner as ICHIA.

TREATMENT: AHH and Accordant may request your medical information from your attending physician, consulting professionals, nurses, therapists, home medical agencies, DME providers, pharmacy benefit companies and health care facilities in order to assist in the coordination of your care. They may also share the medical information received from one of your providers with another of your providers to ensure appropriate continuity of care. These organizations will use your medical information in making medical management decisions, such as certifications for admission, necessary treatment regimens or continuation of rehabilitation services. Some other ways the Program may use or disclose your medical information for purposes related to treatment are:

- **Enrollment in Disease Management Programs:** The Program will disclose medical information obtained from your ICHIA application and your medical claims in the Program with Accordant so that it can contact you about enrolling in ICHIA's disease management programs.
- **Treatment Alternatives:** Accordant or AHH may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Business and Services:** The Program, Accordant or AHH may contact you to tell you about health-related benefits or services that may be of interest to you.
- **Payment:** The Program and ACS may request medical information from you or your providers for the purposes of determining coverage, processing claims and reimbursing you or your providers. For example, we or ACS will request certain parts of your hospital records in order to determine if a pre-existing condition limitation applies or to ensure that the medical record supports the charges listed on the bill. Accordant or AHH may use your medical information to determine if all days of hospitalization were medically necessary. Your medical information may be disclosed to other insurers, including your auto insurer, third parties that may be liable for your services, or workers' compensation insurer for the purpose of coordination of benefits.

ROUTINE HEALTH CARE OPERATIONS: The Program may use and disclose your medical information during routine health care operations, including quality assurance activities, internal auditing, actuarial activities, litigation activities, resolution of complaints or grievances and utilization tracking activities. The Program may engage outside consultants (including actuarial, accounting and legal consultants) to conduct some of the health care operations. In the course of performing their duties, they may use or disclose your medical information. These consultants are

business associates under a contract with the Program and are required to keep your medical information confidential.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: The Program may not disclose your medical information to persons outside of the Program and its business associates for purposes other than described in this notice without your authorization. **You have the right to revoke any authorization you have previously given** by submitting a written statement of revocation to the Program, except to the extent that action has already been taken in reliance on your consent or authorization.

INDIANA LAW AFFECTING YOUR AUTHORIZATION: Indiana law may require an authorization to be in a specific form and issued within a designated time period. In instances where such a law would govern an authorization, the Program will require compliance with that law.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION

RESEARCH: Under certain circumstances, the Program may use and disclose your medical information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: The Program may disclose your medical information to a health oversight agency for activities authorized by law, including, but not limited to, audits of the Program. This type of activity is required under the ICHIA Statute by the Indiana Division of Insurance and other Indiana regulatory agencies. In most cases, however, the information that these agencies review will be aggregate information, not individually identifiable information.

LAW ENFORCEMENT / LITIGATION: The Program may disclose your medical information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, the Program may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

WORKERS' COMPENSATION: The Program may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY / VETERANS: The Program may disclose your medical information as required by military command authorities, if you are a member of the United States armed forces.

AS OTHERWISE REQUIRED BY LAW: The Program will disclose your medical information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR MEDICAL INFORMATION: You have the following rights concerning your medical information. All requests must be made in writing, except as may be authorized specifically under the HIPAA Act:

RIGHT TO REQUEST RESTRICTIONS: You have the right to request certain restrictions on the use and disclosure of your medical information. In those instances where the Program is able to agree to your request, we will abide by the restrictions. However, the Program may not be required to comply with those restrictions.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy any medical information that the Program has in its possession, except as restricted by your treating professional or by law. Generally, your best source for obtaining your medical information, however, will be directly from your health care providers.

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that the Program only contact you at work or by mail. Your request must specify how or where you wish to be contacted and that communication by regular means could endanger you. We will follow all reasonable requests for confidential communications.

RIGHT TO AMEND: You have the right to request an amendment or correction to your medical information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record. Generally, a request to amend or correct medical information will, however, be directed to the health care provider who generated the medical information.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your medical information for any purpose other than for treatment, payment or routine health care operational purposes. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. You will receive one list per year without charge.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically

Charges For Copying Records: ICHIA will charge you for copies of records that you request. The charges will be based on the actual expense to provide such copies and billed to you at the time of providing the copies.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: You may exercise your rights by completing a written request form which is available from ICHIA or one of its business associates. As noted above, ICHIA may charge a fee for any copies you request of your medical information. If you have questions or would like more information regarding any of the rights listed above, please contact Douglas Stratton, Executive Director and Privacy Officer (317) 877-5376.

IF YOU BELIEVE THAT ANY OF YOUR RIGHTS HAVE BEEN VIOLATED: You may file a written complaint with the Program or with the federal Department of Health and Human Services. To file a written complaint with the Program, write to:

Douglas Stratton
Executive Director and Privacy Officer for ICHIA
9465 Counselors Row, Suite 200
Indianapolis, Indiana 46240

The Program will not retaliate against any participant who files a complaint.

DUTIES OF ICHIA: The Program is required to protect the privacy of your protected health information and this Notice provides you with information on our privacy practices to secure your protected health information. The Program will abide by the terms of the Notice currently in effect at any point in time.

CHANGES TO THIS NOTICE: The Program reserves the right to change the provisions contained in this Notice at any time. Any new provisions will be effective for all protected health information that the Program has in its possession. The Program will mail any revised Notice to the address indicated on your enrollment form or such other address you may provide to us from time to time.

INTERNET POSTING OF NOTICE OF CHANGES: The Program will post any change in this Notice or the provisions required under HIPAA on its web page located at onlinehealthplan.com (select "guest", and then select ICHIA).

NOTICE EFFECTIVE DATE: The effective date of the Notice is April 14, 2003.